To: Court Clerk
U.S. Bankruptcy Court
Southern District of New York
300 Quarropas Street
White Plains, NY. 10601

From: Cody Kelley
TDCJ#02267010
McConnell Unit
3001 S. Emily Dr.
Beeville, TX. 78102

Re: Purdue Pharma L.P. Harassment

Last year, I filed a Personal Injury Claim in your court against Purdue Pharma L.P., et al. Case No. 19-23649(RDD). This was done through Prime Clerk, LLC who provided the proof of claim form, processed my completed proof of claim on 6/25/2020 and since has assigned my claim the NO: 58546. Since then, Purdue Pharma has contacted me requesting personal and medical information from me. (Please see the enclosed Purdue correspondence sent to me). I did not initiate any contact nor want to with Purdue. I believe this is an inappropriate tactic to compile extremely sensitive personal information from claimants in the above case to use at a deceptive advantage just like they did when they destroyed me and my family's life by getting us hooked on their opiates. How they they got my contact information, I don't Know! Prime Clerk? This isn't their Attorneys contacting me to offer restitution or relief. It's Purdue Pharma Corporate seeking my personal information outside of any court order, to harass, bully and decieve me. Do I actually even have a claim in your court? Or does Prime Clerk, LLC. work for Purdue Pharma, LLC.. I'm really confused and scared now that Purdue is contacting me for my personal information. Will you please protect me from Purdue Pharma?

Sincerely,
Cody J. Kelley 1-9-2021

PURDUE

Purdue Pharma L.P.
One Stamford Forum
Stamford, CT 06901-3431
www.purduepharma.com

17 NOV 2020

Cody J Kelley
McConnell Unit
3001 S Emily Dr.
Beeville TX 78102

RE: Local Reference Number(s): PFT-000471194_LOG 29420

Dear Cody J Kelley,

Purdue Pharma has received information regarding an adverse experience associated with the use of one of our products. We are interested in obtaining detailed information about the event(s) experienced.

Patient identifier (Initials/ Age/ Gender): **xx/xx/xx**
Product(s): **not specified; please provide**
Reported Adverse Event(s): **not specified; please provide**

Please complete the enclosed follow-up form and return it in the self-addressed stamped envelope which has been provided for your convenience.

Should you have additional questions, please contact the Drug Safety and Pharmacovigilance Department at (888) 726-7535, prompt #2.

Thank you for assisting us in gathering valuable quality and safety information about our products.

Sincerely,
Drug Safety and Pharmacovigilance Purdue Pharma

Enclosures:
Consumer Follow Up Form
SASE

Dedicated to Physician and Patient

Purdue Pharma L.P.
One Stamford Forum
Stamford, CT 06901-3431
www.purduepharma.com

Patient Follow Up Form

Patient Details

First Name: _____ MI ____ Last Name: _____

Address: _____ City: _____

State: _____ Zip Code: _____ Telephone: (_____)_____ e-mail: _____

Sex: M ☐ F ☐ Date of Birth. _____ (dd/MMM/yyyy) Height: ____ft ____in Weight: _____lbs

If you are filling this form out for the patient, please indicate your relationship?: ☐ *Spouse* ☐ *Parent* ☐ *Sibling* ☐ *Child* ☐ *Other (specify):*_____

Use of Product *Please tell us about your use of the product.*

What is the exact name and dosage of the product used?	What are you using this product for?	Date started? (dd/MMM/yyyy)	Date stopped? (dd/MMM/yyyy)

Lot number / exp. date: Is a product sample available for return if needed? ☐ Yes ☐ No

Description of Event(s) *Please tell us about your experience(s) with the product.*

Describe the symptom(s) you experienced while using the product above:	What date did the symptom start? (dd/MMM/yyyy)	What date did the symptom stop? (dd/MMM/yyyy)
1.		
2.		
3.		
4.		

What action did you take with the product in relation to your event(s)? ☐ Continued ☐ Stopped ☐ Reduce dose ☐ Increase dose

Did you see or speak to a health care professional (HCP) regarding the event(s) you experienced? ☐ Yes ☐ No

If 'yes', do we have your permission to contact for additional information? ☐ Yes ☐ No ***If 'yes', please provide HCP contact information below:***

Name:_____ Address: _____

City: _____ State: _____ Zip Code: _____ Telephone: (_____)_____

Medical History *Please tell us about your relevant medical history or known allergies.*

Medical Condition(s)	Onset Date	Ongoing?
		☐ Yes ☐ No
		☐ Yes ☐ No
		☐ Yes ☐ No
		☐ Yes ☐ No

Other current medications *Please tell us about other products or supplements you use.*

Please list the product name(s)	Reason for Use	Dose	Start Date	Stop Date	Ongoing?
					☐ Yes ☐ No
					☐ Yes ☐ No
					☐ Yes ☐ No
					☐ Yes ☐ No
					☐ Yes ☐ No